



Missouri Training Program for Rural Child Welfare Workers

Substance Abuse: The Impact on Children and Families

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Families Children Bureau**
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TRAINER INFORMATION

HANDOUTS:

Affirmations

Alcohol Addiction and Recovery Chart

Alcohol and Drug Assessment (4-8 years old)

Alcohol/Drug Questionnaire

Behavioral Signs and Symptoms of Current Substance Abuse vs. Withdrawal

Common Effects of Excessive Alcohol Consumption on the Family

Create concrete goals for each client individually

Diagnostic Tracks

Drugs of Abuse/Uses and Effects

In-Home Evaluations

Interventions for Substance Abuse

Psychosocial Needs Associated with Fetal Alcohol Syndrome and Fetal Alcohol Effects

Self-Report Screening Methods

Substance Abuse Risk Factors

Ten Questions (assessment)

The C.A.G.E. Questions

Types of Drug Testing

Warning Signs of Relapse

(Handouts above not underlined, have not been assigned a specific spot in the presentation, but are included in the folders given to CD workers).

EQUIPMENT NEEDS:

Computer with PowerPoint

Projector

TRAINER INSTRUCTIONS

Teamwork Agreement:

Timeframes:

Session #1-Substance Abuse: The impact of children and family (3 hrs.)

Session #2-Building Blocks (2 hrs.)

Visual Aids:

Picture of a typical alcoholic (poster)

Props for Family Roles: two duffle bags (stuffed to look heavy)
 one sports jersey or mortar board
 one stuffed animal (preferably a stuffed elephant)
 one clown or jester hat
 a tattered shirt

Breaks:

Session #1-break every hour for ten minutes/2 breaks in the morning

Lunch-in between #1 and #2 Sessions (1 hr.)

Session #2- break every hour for ten minutes/1 break in the morning

Trainer's Guide for Substance Abuse Module

Session #1

Substance Abuse: The impact on children and families

I. The Dynamics of Alcohol & Drug Abuse

- A. Drug Abuse and Brain Chemistry
- B. Patterns of Use
 - 1. Experimental Use
 - 2. Functional Use
 - 3. Dysfunctional Use
 - 4. Harmful Use
 - 5. Dependent Use
- C. Abuse or Dependence
- D. Substance Abuse
- E. Substance Dependence

HANDOUT - Diagnostic Tracks

F. What is Addiction?

II. Indicators of Substance Abuse

HANDOUT – Behavioral Signs of Current Substance Abuse vs. Withdrawal

- A. Signs and Symptoms
 - 1. Gender Differences
 - a) Men
 - b) Women

HANDOUT - Alcohol Addiction and Recovery Chart

2. Children

HANDOUT - In-Home Evaluations

3. Questions for the Social Service worker to consider

HANDOUT – Substance Abuse Risk Assessment

B. Dynamics of Substance Abusing Families

- 1. Family Disease
- 2. Communication in the Home
- 3. Difference in Legal vs. Illegal Use
- 4. Reassignment of roles/responsibilities
- 5. Redefined roles in a substance abusing family

INTERACTIVE – Role play of family

-----BREAK-----

III. The Affect of Parental Substance Abuse on a Child

- A. Behavioral Consequences
- B. Medical Consequences
- C. Psychiatric Consequences
- D. Educational Consequences
- E. Emotional Consequences

F. Pre-natal Exposure

1. Birth defects
 - a) Fetal Alcohol Syndrome
 - b) Fetal Alcohol Effects

HANDOUT - Psychosocial Needs Associated with Fetal Alcohol Syndrome and Fetal Alcohol Effects

2. Developmental Effects
3. Behavior Effects

G. Environmental Risk Factors

1. Inconsistency of family & home environment
2. Exposure to Violence
3. Caregiver-Child Interactions
4. Neighborhood

IV. Substance Abuse & Family Violence

- A. Scope of the problem
- B. Understanding the Nexus: Substance Abuse & Family Violence
- C. Why substance abuse is co-related with child maltreatment?

----- -BREAK- -----

V. Treatment

A. Biological Testing Methods

1. Urinalysis
2. Breath Test
3. Blood Test
4. Hair Follicle Drug Test
5. Fingernail Drug Test
6. Saliva Test

HANDOUT - Types of Drug Testing
Self-Report Screening Methods
Alcohol and Drug Assessment (8 years and older)
Alcohol/Drug Questionnaire
Ten Questions (assessment)
The C.A.G.E. Questions

B. Change Process--Stages of Change

1. Pre-contemplation stage
2. Contemplation stage
3. Preparing for change
4. Action stage
5. Lapse stage

HANDOUT - Affirmations
Warning Signs of Relapse
Return to Alcohol Addiction & Recovery Chart

6. Maintenance stage

C. Adult Drug Court

----- -LUNCH- -----

Session #2
Building Blocks

HANDOUT - Drugs of Abuse/Uses and Effects
INTERACTIVE - Each one teach one/Drug Facts

Slide 1



NOTICE - Both drugs and alcohol will be discussed in this presentation. We may mention one or the other specifically, but please keep in mind that a majority of the content applies to both.




- Most studies indicate that nationally between one-third and two-thirds of substantiated child abuse and neglect reports involve parental substance abuse. In the state of Missouri, the numbers reported indicate 80% of CAN reports involve parental substance abuse.

Drug Abuse and Brain Chemistry

- Our brains work to promote our survival.
- Eating is governed by specific brain systems. When we eat (or do various other activities), the brain's reward systems are activated.
- Activation of brain reward systems produces changes in affect ranging from slight mood elevation to intense pleasure and euphoria, and these psychological states help direct behavior toward natural rewards.
- Other drugs activate the brain's reward centers much more intensely. Use of other drugs can elevate mood as well as other affective changes (relaxation, etc.) that are desirable.
- The enjoyment of this affect can lead to abuse. Since the activation is more intense, it begins to cause cravings for this heightened level of stimulation.

www.addictionscience.net



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- Activation of brain reward systems produces changes in affect ranging from slight mood elevation to intense pleasure and euphoria, and these psychological states help direct behavior toward natural rewards.
- **Caffeine, alcohol, and nicotine** all activate the brain reward mechanisms directly, and moderate use of these substances has grown socially acceptable.
- Other drugs activate the brain's reward centers much more intensely. Use of other drugs can elevate mood as well as other affective changes (relaxation, etc.) that are desirable.
- The enjoyment of this affect can lead to abuse. Since the activation is more intense, it begins to cause cravings for this heightened level of stimulation.
- Over time, continued use of drugs begins to chemically alter the person's normal functioning, decreasing the individual's natural activation of their brain's reward centers, and now more fully relying on the drug to feel good.
- Especially true with methamphetamine.

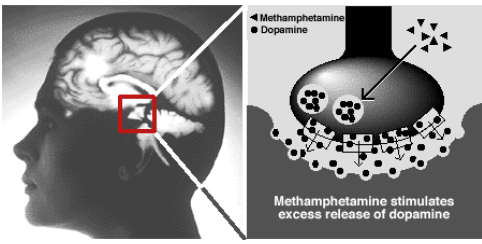
Research has shown that chronic alcohol use makes changes in the brain's chemistry affecting fundamental brain functions. Functions involved in initiation of motor activity and integration of behavior, intellect, and emotion are particularly susceptible to alcohol-induced changes. Alcohol may impair attention, information processing, learning and memory. Alcohol influences two of the brain's neurotransmitters, dopamine and serotonin, affecting stress level, mood, and feelings of pleasure or pain. Serotonin depletion through alcohol or drug use can

lead to depression. Alcohol induced changes to the brain are complex, serious, and may be permanent. It is important that a parent receive a medical evaluation, and that assessments of future risk and permanency planning for the child realistically address parental capacity.

Drug Abuse and Brain Chemistry

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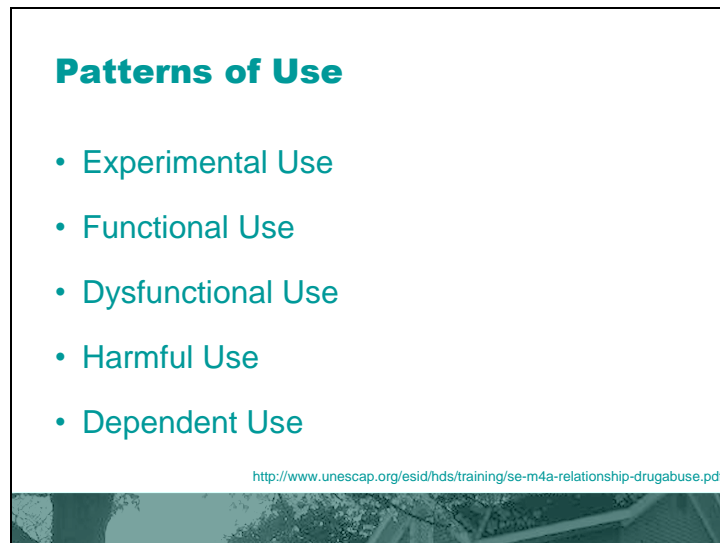
www.addictionscience.net



- “Researchers have reported that as much as 50 percent of the dopamine-producing cells in the brain can be damaged after prolonged exposure to relatively low levels of methamphetamine. Researchers also have found that serotonin-containing nerve cells may be damaged even more extensively.”
- “Although there are no physical manifestations of a withdrawal syndrome when methamphetamine use is stopped, there are several symptoms that occur when a chronic user stops taking the drug. These include depression, anxiety, fatigue, paranoia, aggression, and an intense craving for the drug.”

www.methamphetamineaddiction.com

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Patterns of Use

- Experimental Use

Users begin at this stage with exploratory motivations. They are curious about the different effects (feelings/sensations) that the substances provide. This form of use is typical when the user is entering new developmental stage.
- Functional Use

As the user moves beyond exploration, he/she begins to discover that different substances may be useful to them at different times. At this point the user begins using particular substances for recreation, anxiety relief, to stay awake, to get some sleep, to alleviate hunger, cover pain, or provide an overall sense of happiness and well-being. One common pattern is when a user functionally uses a substance to relax in social settings. Another user may choose a substance that increases energy and alertness for job related reasons. "The motivation to stop usage at this stage is poor since the user is typically experiencing few serious consequences from using."
- Dysfunctional Use

The key markers that a user is entering dysfunctional use are impaired psychological or social functioning. Also, the substance use may begin to interfere with personal relationships. A user may begin calling in sick to work because they are still recovering from a hangover. They begin to feel as though they cannot socialize with their chosen substance. Hygiene, nutrition, and other basic daily tasks begin to be neglected.
- Harmful Use

“Harmful use is marked by damage caused to mental and/or physical health. The harm can be simply a result of becoming intoxicated on the substance. There is also some indirect harm that does not come from the drug, but are related to drug use.

-Injecting a substance increases vulnerability of exposure to HIV and hepatitis, in addition to collapsed veins and overdose.

-Smoking a substance can lead to respiratory system disorders and burns.

Other effects can include traumatic injuries from accidents and violence, suffocation, seizures, overdose, organ damage, and poisoning.

Those experiencing the most harm from drug use are often long-term drug users; however, damage can also occur with experimental/occasional use.”

- **Dependent Use**

At this level, users have difficulty controlling their substance consumption. They may be aware of the significant consequences of continued use, but continue to use regardless of the dangers. They begin to plan their time around the drug. The cycle begins with trying to obtain the drug, use the drug, recover from taking the drug, and then back to trying to obtain more of the drug. At this level, the user will experience both tolerance and withdrawal.

Tolerance happens when the users continuously uses the same substance, but needs more each time to achieve the same affect experience with a smaller amount.

Withdrawal happens when the body begins to adjust for the constant presence of the substance in the body, and if the user stops using the body begins craving the missing substance.

-<http://www.unescap.org/esid/hds/training/se-m4a-relationship-drugabuse.pdf>

Abuse or Dependence

- Abuse and Dependence are seen very differently by the DSM-IV-TR which is used by mental health professionals to diagnose substance abuse problems.
- Substance Abuse precedes Substance Dependence. A person may be using a substance and not qualify as either a substance abuser or as substance dependent.

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Substance Abuse

“A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period”:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments w/ spouse about consequences of intoxication, physical fights)

AND

- The symptoms have never met the criteria for Substance Dependence for this class of substance.

DSM-IV-TR, 2000

Substance Abuse

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

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-DSM-IV-TR

Substance Dependence

“A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period”:

- **Tolerance**, either of the following:
 - a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - markedly diminished effect with continued use of the same amount of the substance
- A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
- Important social, occupational, or recreational activities are given up or reduced because of substance use



Substance Dependence

- **Tolerance**, either of the following:
 - a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - markedly diminished effect with continued use of the same amount of the substance
- **Withdrawal**, either of the following:
 - the characteristic withdrawal syndrome for the substance
 - the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
- The substance is often taken in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
- Important social, occupational, or recreational activities are given up or reduced because of substance use
- The substance use is continued despite knowledge of having a persistent or

recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

-DSM-IV-TR

HANDOUT - Diagnostic Tracks

Substance Dependence Cont.

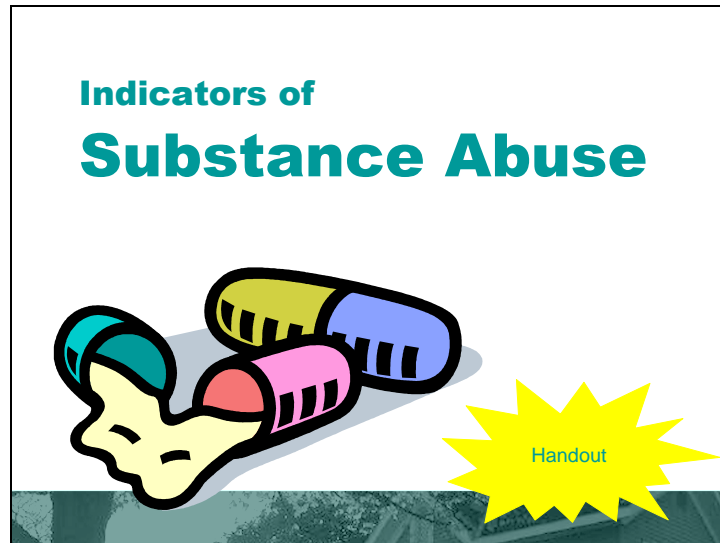
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DSM-IV-TR, 2000

What is Addiction

- **Addiction**
 - Alcohol and drug addiction are diseases that, while treatable, are chronic and relapsing.
 - Chronic and relapsing mean that the addiction is never “cured”, and that substance use may persist or reappear over the course of an individual’s life.

Over time, the disease of addiction causes changes in the person’s body, mind, and behavior, and that a person is unable to control his or her substance use, despite the harm that results.



Signs and Symptoms- Gender Differences

Men

- Men have more access to drugs.
- Men are more likely to abuse alcohol and marijuana than women.
- Men in treatment programs are more likely to have graduate high school and be employed than women in treatment.
- More likely to enter treatment because of referral by the criminal justice system, whereas women enter treatment at the prompting of community, government, or religious organizations.

Women

- Women are more likely to become addicted to or dependent on sedatives and drugs that reduce anxiety or sleeplessness.
- Women are more likely to have other health problems, seek treatment multiple times, and attempt suicide.
- Several research studies indicate that many women begin abusing substances in order to cope with the trauma of the physical/sexual abuse.

The National Institute on Drug Abuse

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HANDOUT - Alcohol Addiction and Recovery Chart
The National Institute on Drug Abuse

http://www.drugabuse.gov/NIDA_Notes/NNVol15N4/tearoff.html


Child Signs and Symptoms

Note: It is possible for there to be other explanations beyond substance abuse in the home for these signs/symptoms. It is important to consider alternate explanations as well.

The child of a substance abuser may:

- Appear unkempt. Can be result of neglect by a substance abusing parent.
- Be frequently sleepy--can be connected to fighting, arguing, or violent behavior in the home in the evening.
- Be late to school--may be in charge of getting themselves there because their parent is still in bed. Their responsibilities in the morning may include preparing breakfast, taking care of younger siblings, etc.
- Have unexplained bruises due to inadequate supervision or abuse from a parent.
- Fluctuate regarding school performance, esp. at the end of the day as the child dreads returning home.
- May have an unchildlike odor (not poor hygiene) but chemical in nature (metallic or cat urine smell). This could indicate drug usage and manufacturing in the home.

www.coaf.org



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Signs and Symptoms (cont.)

The child of a substance abuser may:

- Know too much about drinking for their age or they may be extremely guarded when the topic of substances are approached.
- Appear withdrawn/depressed
- Display behavioral problems.
- Be frequently absent from school in order to take care of the substance abuser
- Complain of stomachaches, headaches, or other physical ailments, with no explainable cause, often at the same time every day
- Peers may tease/hint about problem in the child's home.
- Parents can be predictably hard to reach and often do not show for child's activities at school
- Parent(s) may attend school related functions drunk or high.

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HANDOUT - In-Home Evaluations

Questions for the social service worker to ask or situations to consider...

- Is the client driving with the children in the car while under the influence?
- Are the children being left in unsafe care – with an inappropriate caretaker or unattended while parent is partying?
- Parent may neglect or sporadically address the children's needs for regular meals, clothing and cleanliness.
- Even when the parent is in the home, the parent's use may leave children unsupervised.
- Behavior toward children may be inconsistent, such as a pattern of violence and then remorse.

Questions for the social service worker to ask or situations to consider...

- Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs
- Is the parent able to work? Is the cost of the substance of abuse causing financial issues? Funds are used to buy alcohol or other drugs, while other necessities, such as buying food are neglected
- A parent may not be able to prioritize children's needs over his or her own for the substance

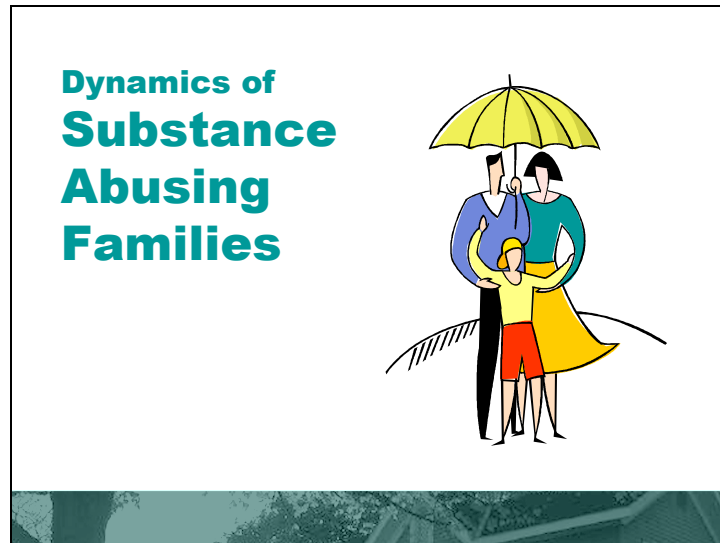
Handout

In-Home Evaluations Handout

Risk Assessment Handout

Substance Abuse Risk Assessment Questions

1. What were the issues that brought the children and/or family to my attention?
2. What is the family's perspective of this problem?
3. How do the current problems impact the *immediate* safety of the children?
4. Am I relying on labels to influence this assessment? If so, what are the behaviors that impact the risk or safety of the children?
5. Have I considered the family's cultural background?
6. How is my personal framework affecting my assessment of the family's problems?
7. What is the evidence that supports my conclusions?
8. What is the evidence that disputes my conclusions?
9. What other evidence should I explore?
10. What could be another explanation for the client's behavior?
11. Have I examined precipitating events as well as consequences of behaviors?
12. What visual signs have I observed of substance abuse?



Family Disease

Substance abuse affects the entire family.

- The need for the substance puts a constant strain on financial resources, and the effects of the substance can threaten long-term employment.
- The increasing stress level in the home can lead to arguing and hostility, verbal, physical, and sexual abuse, and overall chaos for the family.
- The pandemonium in the home leads to anxiety, confusion, and conflict in the children who live there.

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- The pandemonium in the home leads to anxiety, confusion, and conflict in the children who live there.
- No one member escapes the effect of a substance abuser in the home, which makes substance abuse a family disease.
- Children whose parents or other siblings are alcoholics or drug users are at greater risk of developing a substance use disorder. Having an alcoholic family member doubles the risk of a male child later becoming alcohol or drug dependent.

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Communication in the Home

- Marked by inconsistency and unpredictability
- Open and honest communication declines and silence and secrets prevail
- When communication occurs, it is usually fluctuates between silence and anger



Communication in the Home

- Marked by inconsistency and unpredictability


Due to the cycle of use, the child will experience their substance-abusing parent differently at different times, but may not be able to connect the parent's changing behavior to their substance use. On some occasions the parent may be friendly and welcoming. However, just as frequently the parent may sleep for long hours, be unresponsive, or irritable. They may also act erratically when under the influence of a substance—acting hyper, silly, mellow, or even violent.

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Difference in Legal vs. Illegal Use

- Additional Element of Secrecy
- Barrier to Community Resources
- Increased Vulnerability
 - Violence
 - Incarceration of a parent
 - Illegal activity for financial gain
- Rate of Addiction

www.coaf.org



Difference in Legal vs. Illegal Use

The research on substance abuse and its affect on children is centered mostly around children of alcoholics. Some researchers feel that the use of other substances effect children in similar ways. However, there are several differences in effect of different drugs on child development. The nature of the parent's drug of choice determines the parent's drug induced behavior. A stimulant using parent will behave differently than a depressant abusing parent, and so on with users of hallucinogens, opiates, club drugs, etc. The overwhelming difference between some drugs is there legal versus illegal natures. The regular presence of an illegal drug in a child's home brings additional risk factors for the child.

- Additional Element of Secrecy
The child has already learned that they are not to talk about their parent's addiction. In an illegal drug using family, this message will be further reinforced. Talking about the use of the illegal drug has more severe consequences, i.e. jail time, other legal problems, the involvement of DFS, and community rejection.
- Barrier to Community Resources
Since the child is taught to keep the family's secret, he/she is unable to feel safe accessing community resources such as the police, fire department, and other emergency services in emergency situations. The involvement of such organizations could unveil the family's secret and result in serious legal consequences.
- Increased Vulnerability

- Violence
- Incarceration of a parent
- Illegal activity for financial gain

Having illegal drugs in the home, increases the risk for violence and crime to also occur in the home. The child is also consistently at risk for losing a parent to incarceration at any point. They may also be regularly exposed to a variety of illegal activities (drug dealing, prostitution, etc.) to make money to purchase more of the drug.

- Rate of Addiction

The rate of addiction is much faster for illegal drugs than it is for most legal drugs. A parent using illegal drugs can become addicted much faster than an alcoholic or prescription drug abuser.

Reassignment of roles/responsibilities

- Children begin to learn that they cannot rely on the substance abuser to follow through on what they have said.
- Family members adapt by reassigning family roles/responsibilities
- Children may be easily overburden with the tasks of taking care of themselves and their siblings, preparing meals, getting to school alone, caring for the substance abusing parent, etc.
- Due to the family's secret, the child has less support for the stress of their increased responsibilities.

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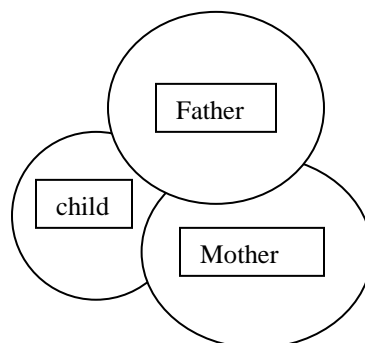
INTERACTIVE – Role play of family

Today we are going to discuss families and family dynamics. You might expect us to discuss normal and abnormal families but here is an example showing why we won't.

Imagine for a moment that you are a foreign exchange student living in your home. When he/she goes back to their native country, what will they tell their families about normal families? Do you eat in front of the TV, do you sleep until noon, etc.

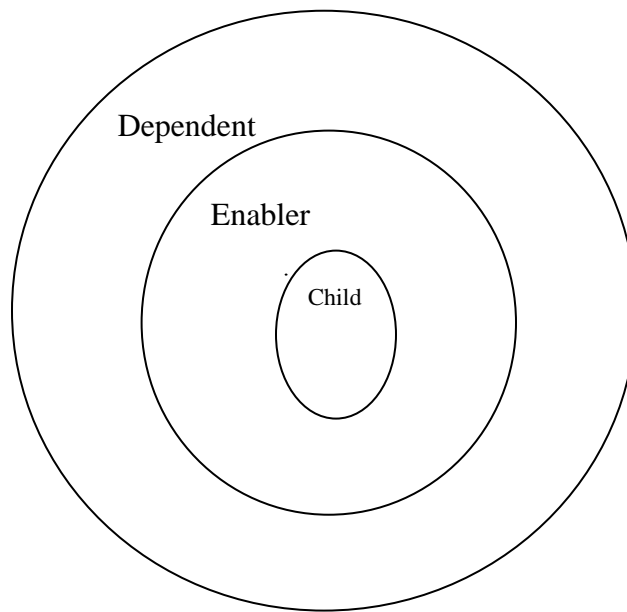
Let's discuss healthy and unhealthy instead. Keep in mind that our clients may take a different structure or interchange the roles from what the model shows.

Draw three circles that overlap



One is the father. He has areas that he overlaps with the mother and they exchange ideas and experiences. There is an area where he overlaps the child. There is where the father/child

sharing takes place and the final place that there is overlap is where all three overlap for sharing and concerns. You will notice there is room around each of the family members for growth and development. Each can expand, take on new interests and develop into the person they want to become.



Now look at this family. The outer ring is the dependent person. He has room to grow and develop. He is developing new friends, new excuses for drinking, not going to work, etc. The next circle is the spouse. He/she is totally engulfed by the user. There is no place to grow that is not restricted. The child is even further inhibited by the enabler and the dependent person.

Family Sculpture

Dependent Person: The user, meaning alcoholic or substance abuser. May be angry, the stern disciplinarian or the unloving, rigidly religious one, aggressive, blaming, manipulative

Place this person on a chair facing the audience. Ask the person if s/he has a specific drink favorite. Ask the person to look out to the back of the room and focus on something above the heads of the audience.

Props: Give this person two large bags to hold up representing the baggage that s/he is carrying around.

Line: “I want a drink! Give me a drink!”

The line is to be repeated in unison with other family members as they join the dependent person.

Enabler: The closest one to the dependent person. S/he allows the behavior to continue out of love, shame, loyalty and fear. Protector of the family, martyr, physically sick

This person is placed so that s/he can help hold the baggage. As how the new character feels.

Props: Help the dependent person hold the bags of emotions.

Line: “Things are fine, really! We’re all doing just fine!”

Dependent person and Enabler say their lines together (Dependent person is focused on back wall)

Hero: Usually the oldest child. Learns they can help the family by being very good. The Enabler leans heavily on her/him for support. Caretaker, high achiever, very responsible

How do you feel about this family. Who will you help.

Hero helps his parents hold the bags and acts as if nothing is wrong.

Props: tennis racket, football jersey – anything that would model success

Line: “Look at me, I’m doing great!”

Dependent person, enabler and hero say their lines together on cue from facilitator.

Scapegoat: usually second child. Cannot compete with hero. Attracts negative peer group, rule breaker, in trouble.

Ask Scapegoat to pick two friends to stand in front with him. His/her actions are designed to keep the family together at the counselors, in the principal’s office

Props: scruffy clothing, gang wear, dark glasses, bandanas, beer cans

Line: “You’re a drunk! You’re nothing but a drunk!” (the scapegoat says this while holding out his arm and pointing at the dependent)

Dependent person, enabler, hero and scapegoat say their lines together on cue from facilitator.

Mascot: Usually the youngest child. Highly anxious about what is going on and thinks she/he is crazy because no one else is addressing it. Is the family clown. Makes everyone relax, cute, hyperactive. Mascot runs around the family tickling them, making faces, anything to get their attention.

Props: funny hat, feather boa, bell

Line: Look at me! Pay attention to me!”

All say their lines.

Lost child: Usually the third child. Handles the chaos by withdrawing. This volunteer is picked but goes to the back of the room or stays in his/her seat. This is the child that every teacher loves. They do their work, they don’t ask questions. They always get by. Teachers often don’t remember their names. Does not feel close to parents or siblings.

Props: a stuffed animal to hug (preferably big)

Line: says nothing

Who will the family blame? Who needs help? What will happen.

As adults:

Enabler will be misdiagnosed and placed on valium for stress
Hero will marry an alcoholic and become the enabler
Scapegoat begins drinking and using illegal drugs early
Lost child may be misdiagnosed and given antidepressants
Mascot may be misdiagnosed and put on Ritalin

Slide 26

Dependent

- In the alcoholic home, it is the drinker.
- In a dysfunctional home, it may be the angry one, the stern disciplinarian, or the unloving and rigidly religious one.
- (Angry, charming, aggressive, grandiose, righteous, rigid, perfectionist)

Job description:


- Aggressor
- Manipulative
- Perfectionist

Baggage:

- Fear
- Pain
- Shame
- Guilt
- Unhealthy, irresponsible behavior

Relief:

- Therapy
- skill building
- support (sponsor)



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Job description:

- Aggressor, Manipulative, Perfectionist

Baggage:

- Fear, Pain, Shame, Guilt, & Unhealthy, irresponsible behavior

Relief:

- Therapy, Skill building, Support (sponsor)

Enabler

- The closest one to the Dependent. They enable their behavior to continue out of love, loyalty, shame and fear.

Job description:

- Responsible for the alcoholic
- Compensates for alcoholic's loss of power
- Caretaker
- Family protector
- Rescuer


Baggage:

- Anger
- Martyrdom
- Self-righteous

Relief:

- Positive adult connections
- Validation of self worth

(Powerless, self-pities, self-blames, serious, fragile, manipulative, super-responsible)



Enabler

They enable the dependent's behavior to continue out of love, loyalty, shame and fear.

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- Responsible for the alcoholic, Compensates for alcoholic's loss of power, Caretaker, Family protector, Rescuer

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(Powerless, self-pities, self-blames, serious, fragile, manipulative, super-responsible)

Hero

- Usually the oldest child
- Learns they can help the family most by being very, very good.
- The Enabler leans heavily on them for support. The Mascot tags on them for attention.

Job description:

- Perfectionist
- Excellent student
- Over-achievers
- Makes family look good
- Follows rules

Baggage:

- Guilt
- Hurt
- Inadequacy

Relief:

- Permission to make mistakes and not be perfect
- Opportunities to play
- Opportunities to express feelings and needs



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Scapegoat

- Usually the second child
- Cannot compete with the Hero. Attracted to peers who are in negative environments.

Job description:

- Problem child
- Accepts blame for family problems
- Seeks approval outside family
- Provide distraction and focus to family
- Aggressive
- Behavior problems
- Acting out may include use of ATOD


Baggage:

- Anger
- Hurt
- Rejection
- Jealousy

Relief:

- Permission to be successful
- Supportive confirmation
- Structure and consistency

(Strongly values peers, withdraws, unplanned pregnancy, chemical abuser, sullen, acts out, defiant)



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Relief:

- Permission to be successful, Supportive confirmation, Structure and consistency (Strongly values peers, withdraws, unplanned pregnancy, chemical abuser, sullen, acts out, defiant)

Lost Child

- Usually the third child
- Handles the chaos by withdrawing. Does not feel close to parents or siblings.
- Passive and never sure where they fit. May get lost in alcohol and drug abuse.

Job description:

- Forgotten Child
- Dreamer
- Attaches to things, not people
- Solitary, anti-social
- Artistic
- Provides relief to family

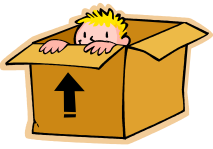
Baggage:

- Rejection
- Invisibility
- Anxiety
- Depressed, suicidal

Relief:

- Positive attention
- Encouragement to take chances
- Feel connected to other people

(Withdrawn, aloof, eating disorder, quiet, distances, rejects, super independent)



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(Withdrawn, aloof, eating disorder, quiet, distances, rejects, super independent)

Mascot

- Usually the youngest child
- Develops wit and humor becoming the family clown. Their task is to help the family relax. May be hyperactive and be put on drugs, becoming dependent.
- Primary emotion is fear. May imagine physical disaster with every pain.

Job description:

- Clown
- Cute
- Hyper-active
- No honest communication
- Manipulative


Baggage:

- Fear
- Insecurity

Relief:

- To be taken seriously
- To hear that your opinions count
- Support and validation of all feelings

(Humorous, hyperactive, fragility, clown, always attracting attention, thrives on being super cute)



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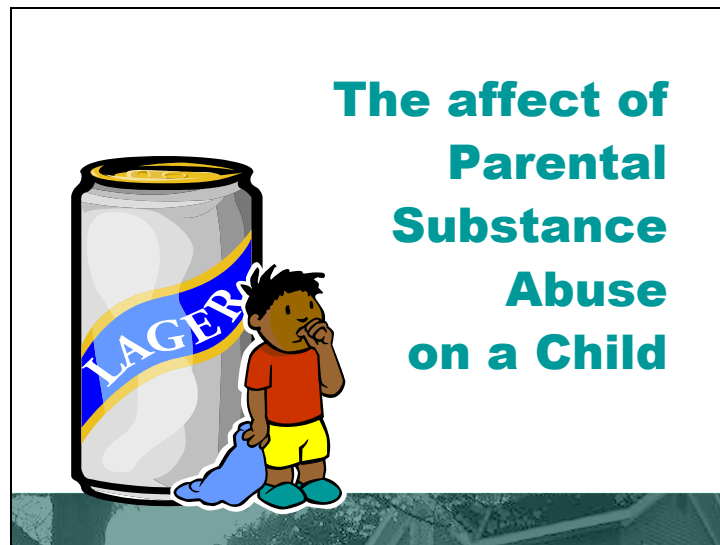
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(Humorous, hyperactive, fragility, clown, always attracting attention, thrives on being super cute)



“When parents become preoccupied with drugs, or any other activity which dominates and monopolizes their time and energy, the children become emotional and sometimes physical cripples as a result of deprivation. Though the children are innocent they still become partners locked into this problem. Their coping skills become frustrated and their needs are invariably short-circuited. Such children carry these inappropriate adaptive behaviors with them into adulthood and create an inter-generational cycle of maladaptive coping techniques,” (Briggs, 1970).

Briggs, D.C. (1970). Your child's self-esteem. New York: Doubleday.

Recent research continues to validate this statement made over 30 years ago.

Behavioral Consequences


- Substance abuse interrupts normal child development
- Family life is often chaotic since parental substance abuse is often combined with several of the following factors: domestic violence, divorce, unemployment, mental illness, legal problems, physical and sexual abuse
- As a result of these stressors, children of substance abusers often have difficulty in school. They may be distracted from school work by their concerns at home. COSA are more likely to skip school, repeat grades, transfer schools, be expelled, and have difficulty learning.

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Medical Consequences

- Stress-related health problems
- Health care utilization
- Child abuse and neglect
- Alcoholism and other drug dependence



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- Effects lasting into adulthood




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Pre-natal Exposure

- **Birth defects**
 - Fetal Alcohol Syndrome
 - Primary symptoms
 - Prenatal and postnatal growth deficiency (failure to grow). FAS children tend to begin with a lower birth weight and grow significantly less than other children their age. Their growth is below the 5th percentile for their age.
 - Characteristic facial features include: flattened mid-face, epicanthal folds on the eyes, short/upturned nose, thin upper lip
 - Average I.Q = 68 to 70 (mild range of mental retardation)
 - Irritability in infancy, hyperactivity, and other emotional and behavioral disorders throughout childhood, including attention deficit disorder (ADD) or with hyperactivity (ADHD), and poor social judgment.
 - Dysfunction in fine motor control: weak grasp, poor eye-hand coordination, and tremulousness
 - Fetal Alcohol Effects
 - Lesser degrees of alcohol-related birth defects



Hughes, 1998

HANDOUT - Psychosocial Needs Associated with Fetal Alcohol Syndrome and Fetal Alcohol Effects

Pre-natal Exposure

Birth defects

Fetal Alcohol Syndrome-

“Incidence of FAS is estimated at 1 to 3 per 1,000 live births. Studies estimate that 10 to 20% of mild mental retardation and low-normal cognitive functioning are the result of prenatal exposure to excessive alcohol. Among alcoholic women who drink during pregnancy, approximately 35 to 40% of their infants will have fetal alcohol syndrome, and up to 3 times as many will have fetal alcohol effects.”

Hughes, p. 91-93

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 - Lesser degrees of alcohol-related birth defects (Hughes)

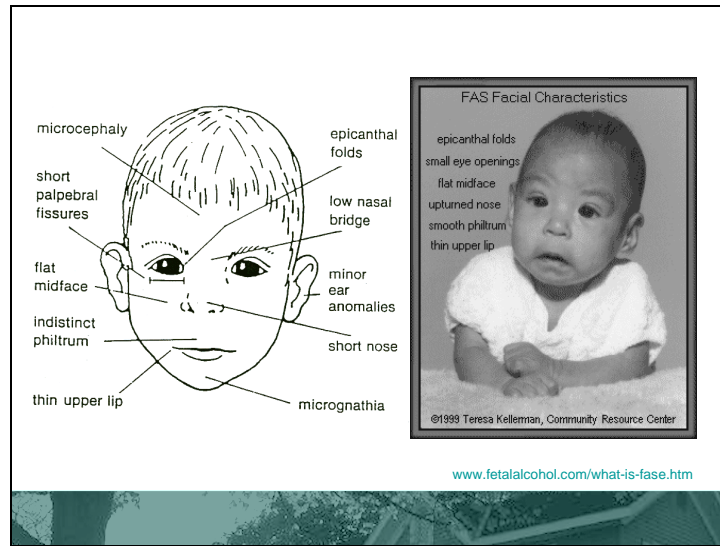
Developmental Effects

- Pre-maturity, low birth weight, decreased head circumference, impaired neurological function, neuromotor problems, intraventricular hemorrhage, strokes, & congenital malformations.

Behavior Effects

- High-pitched cries, tremors, inconsolability, irritability, inability to organize normal sleep-wake cycles, and hyperactivity when exposed to multiple stimuli. (May foster poor child-caregiver attachment and affect later development).
- Later on: more insecure, more disorganized, and more poorly attached to their primary caregiver, more inattentive, and impulsive. (Besharov)

Slide 39



Pre-natal Exposure (cont.)


- **Developmental Effects**
 - Pre-maturity, low birth weight, decreased head circumference, impaired neurological function, neuromotor problems, intraventricular hemorrhage, strokes, & congenital malformations.
- **Behavior Effects**
 - High-pitched cries, tremors, inconsolability, irritability, inability to organize normal sleep-wake cycles, and hyperactivity when exposed to multiple stimuli. (May foster poor child-caregiver attachment and affect later development).
 - Later on: more insecure, more disorganized, and more poorly attached to their primary caregiver, more inattentive, and impulsive.

Besharov, 1994

Pre-natal Exposure (cont.)

- FAS & overall substance abuse long-term prognosis
- “Sleeper Effect”
- The research on pre-natal substance exposure is difficult to generalize since it often only takes into consider one drug and its affect on one particular age group and population.
- It is also unknown to what extent the effects seen in the child are due to the pre-natal drug exposure or the child’s current environment and their caregiver’s interaction with them.
- Pre-natal damage is largely unpredictable, one woman who excessively abused substances may give birth to a normal infant and another woman who casually drank on occasion may give birth to a child with severe substance abuse related difficulties.

(Hughes, 1998, Haack, 1997, & Besharov, 1994)



- FAS & overall substance abuse long-term prognosis
Fetal Alcohol Syndrome- With age physical factors diminish/disappear, cognitive/emotional patterns last. Most children remain mentally retarded and severe psychological disorders are common (conduct disorders, ADD, ADHD, emotional disorders, speech disorders, and problems in social relationships. The greater the substance exposure the more significant the damage to intellectual and emotional functioning.
Overall substance exposure- Cognitive/Social effects appear to remain throughout life.
- “Sleeper Effect”
Children may show signs mentioned previously at birth, (low birth weight, head circumference, etc.) of substance exposure. However, their development after birth up until 2-3 years old may appear the same as children not exposed to substances. At that point, signs may begin to reappear (lower verbal and reasoning scores & maternal reports of problem behavior). Why this occurs is relatively unknown and is a focus of current research. Haack p. 65-66
- The research on pre-natal substance exposure is difficult to generalize since it often only takes into consider one drug and its affect on one particular age group and population.
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Hughes, 1998, Haack, 1997 & Besharov, 1994




“Children exposed prenatally to alcohol and other drugs are raised in varied environments, often characterized by the presence of multiple factors of substantial risk and few protections or curative influences. These factors must be considered in understanding their developmental outcomes.” Haack p. 70-73

Inconsistency of family & home environment

- “Women who continue to abuse substance after the birth of their child often lose custody of their child within 1 year of their child’s birth. In some areas of the country, as many as 60% of drug-exposed infants are placed in foster care.”
- This removal may begin a series of placements in different foster homes. This will result in multiple caregiver relationships from which the child is expected to attach and unattach. The resulting loss and grief makes the child more vulnerable to experience emotional and behavioral problems during their childhood.

Haack, 1997



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Haack

Check www.dmh.missouri.gov/ada/rpts/status.htm for current statistics on out-of-home placements in relation to drug abuse. NOTE: The statistics appear to be inaccurate at times due to documentation.

Exposure to Violence

- Drug-abusing mothers are more than likely to be around other drug abusing family members and friends. The mothers and children living in these type of environments are more likely to witness violence as well as be victims of it.
- “A growing body of evidence indicates that witnessing violence can have a profound affect on children’s social and emotional outcomes. Underscoring this point, some researchers have concluded that children growing up in violent neighborhoods have begun to display symptoms of post-traumatic stress disorder, including depressed interest in activities, guilt, violent outbursts and rage, difficulty concentrating, and a decline in cognitive performance.”

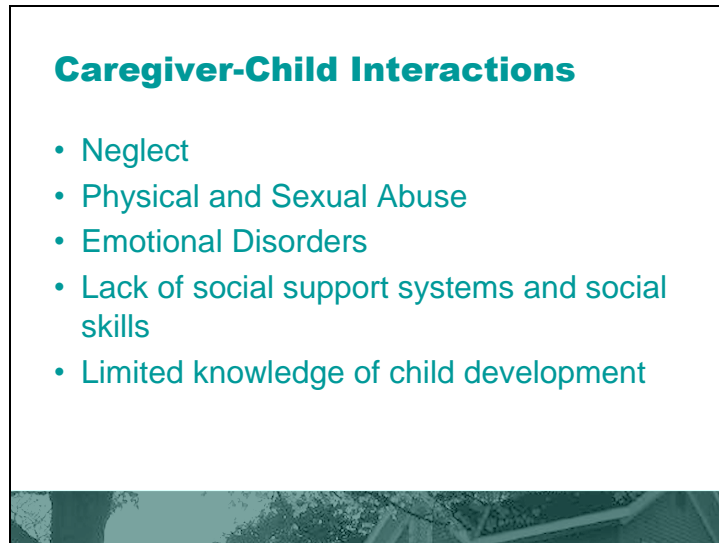
Besharov, 1994



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Besharov




Caregiver-Child Interactions

- **Neglect**
- **Physical and Sexual Abuse**
Drug-abusing women are frequently victims of physical and sexual abuse for many reasons. If they are estranged from their family, homeless, or willing to exchange sex for drugs they are at even greater risk for being victims of violence. When the mother is not safe, neither are her children.
- **Emotional Disorders**
“A recent prevalence study by the National Institute on Mental Health estimated that individuals with a history of alcohol or drug abuse are seven times more likely to suffer from mental disorders than individuals in the general population.”
- **Lack of social support systems and social skills**
Drug-abusing mothers have difficulty in basic social functioning, i.e. managing finances, locating appropriate child care, pursuing educational and vocational activities, and utilizing community resources. Their lack of social support only further isolates them from getting the help they need. If involved in an intimate relationship, it may be inadequately supportive or negative.
- **Limited knowledge of child development**
“Their limited education in general and their lack of continuing well-child pediatric follow-up result in fewer opportunities for caregivers to gain knowledge of child development. Sometimes this lack of understanding leads to unrealistic behavioral expectations of their children. These unrealistic expectations can result in authoritarian and excessively negative approaches to parenting.”

Neighborhood

- Environment of stress and poverty
- Dangerous or unsanitary living Conditions
- Stable families move from the area
- The parent develops a loyalty to neighbors that exceeds the loyalty to their child
- Little supervision
- High unemployment (potential for dangerous teenagers and adults to be home during the time a child is left alone—after school).
- CAUTION- meth environments

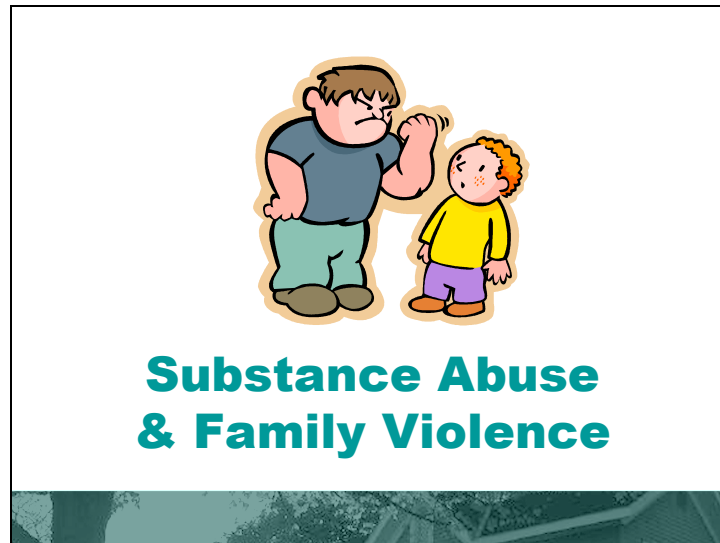


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- CAUTION- meth environments

Often parents in substance abuse environments develop a loyalty to their fellow community members that takes precedence to the parenting of their own child.

Example: A parent may find it more important to lend money to a fellow user than to use the money for groceries. The parent may allow inappropriate people to have contact with their children because of the loyalty they feel towards that person.



VI. SUBSTANCE ABUSE AND FAMILY VIOLENCE

A. INTRODUCTION

The association between and family violence has been well documented. For many years, experts have tried to explain the relationship between substance abuse and family violence, but researches have demonstrated that substance abuse by itself does not cause violence. Most studies that link substance abuse with domestic violence have focused upon alcohol, not illicit substances (Woerle et al. 18). Studies focused on alcohol agree that alcohol facilitates or “triggers” rather than causes the assault and is often used to legitimize or excuse the violence (Appleford 7). Furthermore, the relation between alcohol and violence is most affected by multiple factors such as personality, provocation and threat as well as learned alcohol expectancies, situational factors and biochemical factors (Von der Pahlen 21).

Scope of the problem

- The risk of child abuse and neglect is higher in families where parents abuse substances. The highest incidence of abuse and neglect occurs in families where both parents abuse alcohol.
- Parental substance abuse may leave children more vulnerable to sexual abuse by family members or by strangers
- Laws in several states support that maternal drug use is a form of child abuse and neglect.

B. SCOPE OF THE PROBLEM

Typically, substance abusing parents have histories of abuse or deprivation in childhood and in turn treat their children similarly. It is estimated that about one-third of abused children will one day abuse their offspring (“The costs of Child Abuse and the urgent need for prevention”, 2).


There has been some support of the associations between alcohol and violence, with research investigating homicide, assault and domestic violence. (Tomison 2).

Child welfare workers need to be aware that the risk of child abuse and neglect is higher in families where parents abuse substances. The highest incidence of abuse and neglect occurs in families where both parents abuse alcohol (Ryles 2). Moreover, parents who use drugs may leave children more vulnerable to be abused or their use may result in inadequate supervision and/or failure to ensure children’s safety (Spatz 54). Finally, the link between substance abuse and child maltreatment has particular implications for the unborn child. Infants from substance-abusing families frequently inherit the consequences of their parents, particularly their mother’s actions. The prenatal effects of alcohol and drug use in pregnancy include spontaneous abortion, premature birth, fetal distress, physical and/or mental retardation, birth defects and

withdrawal symptoms upon birth (Tomison, 10). To address the issue of prenatal effects of alcohol and drug use, a number of states have passed laws stating that all children exposed to substance in utero require protective investigation. Some states use maternal drug use as evidence for child abuse cases (“Parental Substance Abuse” 6).

**Understanding the Link:
Substance Abuse & Family Violence**

- Substance abuse is one of the top two problems exhibited by families in 81% of reported cases of child abuse and neglect. Bersharov
- 11 percent of US children (8.3 million) live with at least one parent who is either alcoholic or in need of treatment for substance abuse
- Between 30 and 40 percent of family violence cases were committed while the abuser was taking a psychoactive substance prior to the episode of intimate partner violence. Most commonly reported illegal substance from the urinalysis was marijuana. www.coaf.org
- Highest rates of removal of a child were found for parents who abused illicit drugs, with about 90% of these parents remaining unable to care for their children, compared with an approximately 60% rate of removal for children whose parents abused alcohol. Haack
- A Green Greene County study shows that 60% of clients served in its shelter were assaulted by methamphetamine's users at the time of the offense.



C. RESULTS FROM RESEARCHES

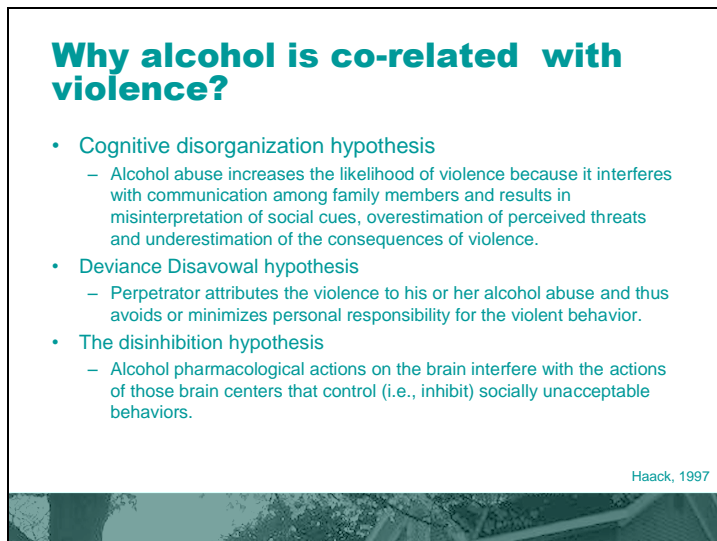
The trainer needs to address the most relevant points that are cited below and that appear in many studies results relating to substance abuse and violence. Also, it is important to communicate to attendees that the impact of stress, divorce, the likelihood of illegal activity in the house, the lack of positive parenting models for numerous generations, the possibility that children have a temperament that makes them more difficult to parent resulting from their parent's addiction, all these factors combine to make the mixture of violence and addiction more likely and more harmful for the children caught up in that mixture.

Some researchers contend that in all substance abusing families, children experience some degree of neglect, including serious neglect ("Parental Substance Abuse" 6). Thus, social service workers need to be aware that:

- Substance abuse is one of the top two problems exhibited by families in 81% of reported cases of child abuse and neglect. Children of substance-abusing parents are three times more likely to be abused and four times more likely to be neglected than parents who are not substance abusers ("The costs of Child Abuse and the urgent need for prevention" 2)
- 11 percent of US children (8.3 million) live with at least one parent who is either alcoholic or in need of treatment for the abuse of illicit drugs ("The costs of Child Abuse and the urgent need for prevention" 5).
- Violent patterns of spousal relationships usually are passed onto the children, beginning an intergenerational cycle that can perpetuate itself indefinitely. Results suggested that exposure to domestic violence during childhood, either as a victim or

witness is a strong predictor of domestic violence ('The costs of Child Abuse and the urgent need for prevention" 5).

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- Highest rates of removal of a child were found for parents who abused illicit drugs, with about 90% of these parents remaining unable to care for their children, compared with an approximately 60% rate of removal for children whose parents abused alcohol ("Parental Substance Abuse" 6).
- A recent (Spring 2005) informal Greene County study shows that 60% of clients served in its domestic violence shelter were assaulted by methamphetamine's users at the time of the offense.



Why alcohol is co-related with violence?

- Cognitive disorganization hypothesis
 - Alcohol abuse increases the likelihood of violence because it interferes with communication among family members and results in misinterpretation of social cues, overestimation of perceived threats and underestimation of the consequences of violence.
- Deviance Disavowal hypothesis
 - Perpetrator attributes the violence to his or her alcohol abuse and thus avoids or minimizes personal responsibility for the violent behavior.
- The disinhibition hypothesis
 - Alcohol pharmacological actions on the brain interfere with the actions of those brain centers that control (i.e., inhibit) socially unacceptable behaviors.

Haack, 1997

D. MECHANISM LINKING ALCOHOL AND VIOLENCE

Social service workers also should be aware that there are some explanations proposed for alcohol-related aggression that can be divided into one of the following three categories depending upon the role assigned to alcohol: (1) The cognitive disorganization hypothesis, (2) The deviance disavowal hypothesis and (3) the disinhibition hypothesis (Spatz 53).

- Cognitive Disorganization hypothesis

Alcohol abuse increases the likelihood of violence, because it interferes with communication among family members and results in misinterpretation of social cues, overestimation of perceived threats and underestimation of the consequences of violence (Spatz 53).

- The Deviance Disavowal hypothesis

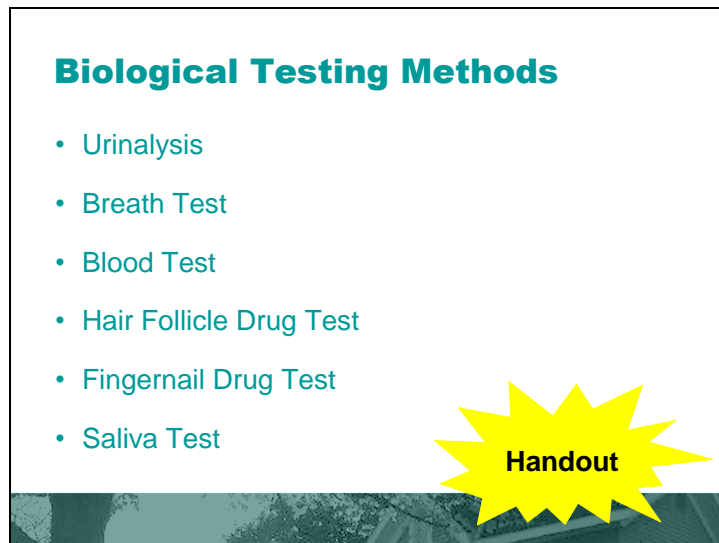
In many societies, intoxication is considered as “time-out” behaviors during which a person is not responsible and accountable in the same sense as under sober conditions. People learn by observing individuals being excused and forgiven for aggressive behavior under intoxication (Von der Pahlen 22). In other words, the offender, after drinking and committing a violent act blame the alcohol for their behavior. For example, a father may drink in order to beat his partner and/or children with minimal guilt

- The Disinhibition hypothesis

People usually try to inhibit inappropriate behavior, but alcohol intoxication blocks the brain center that normally reduces social taboos. Alcohol is also thought to alter judgment by disrupting or weakening normal functions in the brain (Von der Pahlen 22). A study shows that Alcohol was used as a disinhibitor in between 19 to 70 percent of reported cases of sexual offending reported cases. Other studies have reported that incest offenders were more likely to be characterized as alcoholics and to have used alcohol at the time of the offence, than were non-incestuous sex offenders. Indeed, incest offenders appear to have the most extensive histories of alcohol of all sex offenders. Then, the hypothesis may be valid since sexually abusing one's own child would require the breaking down of more inhibitions than the abusing of a child where there is no existing familial bond and less stringent social norms (Tomison 7).

Assessing for Substance Abuse





HANDOUT - Types of Drug Testing

Biological Testing Methods

- **Breath Test**
This is the most common form of assessment used to determine the presence of alcohol. It is widely used because it is noninvasive, accurate when properly administered, portable, inexpensive, quick, and easy to use. Although it would be convenient to have a similar test for drugs, a reliable method has yet to be developed. This tool is typically used as a screening tool, followed by additional assessment.
- **Urinalysis**
This test can provide information on the presence of both alcohol and drugs. It also provides more specific information beyond whether the drug is in the bloodstream; it can also measure the amount of the drug present. For most drugs, the test can detect use within the last 2 to 3 days. Heavy cannabis or phencyclidine use can be detected for up to a week or longer. It cannot, however, determine if the client is currently intoxicated, how much they use, or how often they use. Although false positive are possible, false negative are much more common.
The tests results can be altered by the user placing someone else's urine in their cup or by adulterating the urine sample to interfere with its analysis (i.e. putting bleach in the sample).
- **Blood Test**
Various blood tests can tell the examiner about heavy alcohol use from the past weeks to years. Another test shows them information regarding recent heavy

drinking. However, the tests' accuracy is affected by the overall health of the individual, and the presence of other drugs. Due to the low reliability of blood tests, they are typically only used for screening questionnaires and a client's clinical record.

- **Hair Follicle Drug Test**

The test requires a sample of hair about the width of a pencil. These are cut - not pulled - from close to the scalp to obtain the most recent growth. At the lab, the hair sample is washed clean of any outside contaminants such as shampoo, styling gel, and natural oils, and then melted into liquid. The sample is screened like a urine sample, and five types of drugs - stimulants, pot, coke, opiates and PCP - can be detected.

The hair drug test can accurately detect a history of drug abuse in the subject. While urine and saliva only show current and recent drug use, hair can provide a three month record. Because hair grows at the rate of one half inch per month, a 1 ½ inch sample will show any drugs used within the last 90 days. However, the hair drug test cannot identify drugs used within the last five to seven days, invalidating it for immediate use.

Hair samples are also difficult to tamper with, unlike urine, which can be diluted or contaminated. Bleaching your hair does not make a difference and even if the strands are cut, hair may be taken from elsewhere on the body; including the pubic region, under the arm, or from the leg.

The only problem with relying 100 percent on a hair drug test is that the results may be skewed slightly according to the shade, and type, of your hair. Dark hair retains residue better than light hair, and so does African-American hair, which is far more porous than Caucasian hair.

- **Fingernail Drug Test**

The fingernail clippings can be tested for the presence of drugs. The major disadvantage of this method is that it takes 5 to 6 months of growth before a nail can be clipped. Thus, recent drug use cannot be detected or measured. The most useful application of this method is in the post-mortem setting.

HANDOUT -

Self-Report Screening Methods

Alcohol and Drug Assessment (8 years old and older)

Alcohol/Drug Questionnaire

Ten Questions (assessment)

The C.A.G.E. Questions

Michigan Alcoholism Screening Test (MAST)

- 25 Yes/No Questions-- relating to primarily negative consequences (whether physical, psychological, family, or legal) of alcohol use.
- Questions are weighted differently (in a range of 1 to 5).

- A total score of 0 to 53 is possible, and a score of 5 or higher is suggestive of alcoholism.
- The test takes 15 to 20 minutes to give
- One problem is that a past alcohol problem may trigger a higher score, but the person may not currently be abusing it. Closer examination by the interviewer can determine the whether the problem was in the past or present.

Drug Abuse Screening Test (DAST)

- 20 Yes/No Questions
- Scores are not weighted and range from 0 to 20. A score of 6 or higher indicates the presence of drug problems.
- The test can be self-administered or administered by an interviewer.
- The DAST has the same problem as the MAST in determining the time during which the drug problem existed. As with the MAST, an interviewer will be able to determine the time period of the problem.

CAGE

- “The test name is an acronym of letters of words in the only four items that make up the test:
 - Have you ever felt you should **CUT** down on your drinking?
 - Have people **ANNOYED** you by criticizing your drinking?
 - Have you ever felt **GUILTY** about your drinking?
 - Have you ever had a drink first thing in the morning (**EYE** opener)?”
- 2 to 3 YES answers indicate a problem.
- No time referent like MAST and DAST

Alcohol Use Disorders Identification Test (AUDIT)

- 10 item screening test designed for medical settings
- A score of 8 or higher is indicative of an alcohol problem
- Testing takes only a few minutes and scoring is even quicker
- Well-supported reliability and validity

Mac Andrew Scale (MAC)

- An alcohol screening test that does not discuss alcohol, its use, or consequences related to use.
- “The MAC consists of 49 items from the Minnesota Multiphasic Personality Inventory (MMPI) that have been shown to discriminate empirically between alcoholics and other groups. The MAC is self-administered.”
- True/false questions—takes 15 minutes
- Those scoring 23-27 possibly have a problem, and those scoring 28 and higher most likely do.
- May have false positives for nonalcoholic drug users, heavy cigarette smokers, and heavy users of caffeine.

-Connors, Donovan, & DiClemente (2001)

Substance Abuse Subtle Screening Inventory (SASSI)

- 93 question screening inventory, 67 of which are true/false question.
- A client may take 15 minutes or less to complete the survey and it can be interpreted in only a few minutes.
- SASSI is 94% accurate when identifying those with substance dependence disorder.
- SASSI is 93% accurate when identifying those without substance dependence disorder
- This test can tell if someone is a substance abuser even if they themselves do not believe they are.
- Scoring is different for males & females
- Ten subscales: FVA, FVOD, SYM, OAT, SAT, DEF, SAM, FAM, COR, & RAP
 - Face-Valid Scales
 - FVA (Face-Valid Alcohol)
 - FVOD (Face-Valid Other Drugs)
- The face-valid scales are straightforward measure of acknowledged alcohol and drug use, motivation and consequences of usage, and loss of control.
- A FVA of 18 or more and/or a FVOD of 16 or more indicate substance dependence disorder.

SYM (Symptoms of Substance Misuse)

- A true/false measure of the extent to which the client acknowledges specific problems associated with substance misuse.
- Clients with elevated SYM scores have acknowledged a pattern and history of serious substance misuse, including negative consequences and being a part of a family system that is affected by addictions.
- A score of 7 or more indicates substance dependence disorder.

OAT (Obvious Attributes)

- The OAT scale measures the client's tendency to acknowledge characteristics commonly associated with substance abuse.
- Clients with elevated OAT scores have acknowledged characteristics associated with substance abuse. They are showing a response pattern similar to people in treatment for substance dependence disorders.
- A score of 10 or more indicates substance dependence disorder.

SAT (Subtle Attributes)

- The SAT scores reflect the client's similarity in basic personal style to persons involved in addictive patterns.
- The SAT levels are still elevated even if the client tries to "fake good".
- Those who score high on the SAT scale may often detach from their feelings and have relatively little insight into the basis and causes of their problems. Clients with high SAT, esp. those with SAT higher than OAT may deny the need for intensive treatment.

- A SAT score of 6 or more indicates substance dependence disorder.

DEF (Defensiveness) & SAM (Supplemental Addiction Measure)

- Identifies defensiveness. Defensiveness may be related to substance misuse in some clients, but not in others. The SAM scale distinguishes people defensive about substance misuse from other defensive people.
- DEF and SAM are important because some clients' defensiveness may prevent their identification by other SASSI scales and by other screening measures.
- An OAT of 5 or more, a DEF of 8 or more, AND a **SAM** of 8 or more indicates substance dependence disorder.

FAM (Family vs. Control Subjects)

- FAM is a provisional scale intended to identify individuals with characteristics common among family members of substance dependent persons.
- Those with a high FAM are not typically substance dependence, but have family members who are.
- FAM is not used to determine substance dependence disorder.

COR (Correctional)

- The COR scale assesses the client's relative level of risk for legal problems
- The COR items were selected because they identified adults with relatively extensive histories of problems with the legal/judicial system.
- While clients with high COR scores often have alcohol and drug problems which must be addressed, high COR scores suggest recovery from substance dependence may not be all they need.
- COR is not used to determine substance dependence disorder.

RAP (Random Answering Pattern)

- The RAP scale identifies test profiles in which the client's responses may not be meaningful.
- The RAP items are questions which almost everyone answers the same way. Clinical experience has confirmed their utility. Elevated RAP scores are associated with decreased accuracy in the decision rules and lessen the utility of clinical hypotheses derived from scale scores.
- A RAP score of two or more may alter the meaning of a SASSI profile.
- RAP could also be elevated by: illiteracy, language problems, cultural differences, confusion when marking true/false, losing one's place when marking the form, deliberate noncompliance, passive-aggressive behavior, or psychotic processes or other thought disorders.

Addiction Severity Index (ASI) (ISAP)

- The Short Guide to the ASI is available at:
www.tresearch.org/resources/manuals/SHORTguide%20asi.pdf
- Interactive interview or computerized testing

- *Assesses the following six areas: medical, employment/support, drug/alcohol, legal, family/social, and psychiatric*
- *Used by Carol Jones Recovery and others in the area.*

Interviewer Rating Scale

0 – 1 No real problem, treatment not indicated.

2 – 3 Slight problem, treatment probably not indicated.

4 – 5 Moderate problem, some treatment indicated.

6 – 7 Considerable problem, treatment necessary

8 – 9 Extreme problem, treatment absolutely necessary

Patient Rating Scale

0 – None, Not at all

1 – Slightly

2 – Moderately

3 – Considerably

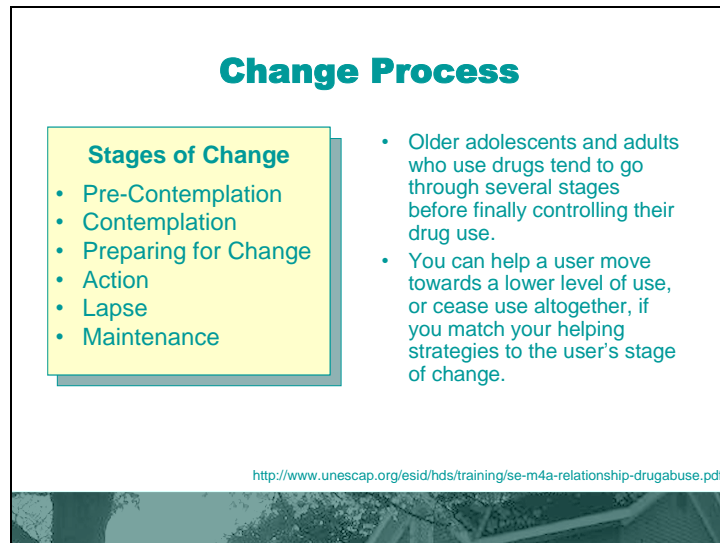
4 – Extremely

The Change Process



<http://www.ioc.org/img/four%20seasons.jpg>



A presentation slide titled "Change Process" in bold teal text. On the left, a yellow box with a teal border is titled "Stages of Change" and lists six stages: Pre-Contemplation, Contemplation, Preparing for Change, Action, Lapse, and Maintenance. To the right of this box, two bullet points in teal text provide additional context: older adolescents and adults go through several stages before controlling drug use, and users can be helped to move to a lower level of use or cease use by matching helping strategies to their stage of change. At the bottom, a URL is provided: http://www.unescap.org/esid/hds/training/se-m4a-relationship-drugabuse.pdf. The slide has a dark teal footer image showing a landscape with trees and a path.

Change Process

Stages of Change

- Pre-Contemplation
- Contemplation
- Preparing for Change
- Action
- Lapse
- Maintenance

- Older adolescents and adults who use drugs tend to go through several stages before finally controlling their drug use.
- You can help a user move towards a lower level of use, or cease use altogether, if you match your helping strategies to the user's stage of change.

<http://www.unescap.org/esid/hds/training/se-m4a-relationship-drugabuse.pdf>


Change Process--Stages of Change

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Pre-contemplation stage

- In this stage, the user is not considering giving up drugs. In response, you work at forming a relationship with the person and try to raise his/her awareness of the consequences of drug use for him/herself, his or her family, and the community.
- **But don't push too hard!** At this point, your main job is to make a connection with them to involve him/her in thinking about changing his/her life.
- DENIAL- "Don't Even kNow I Am Lying"

<http://www.unescap.org/esid/hds/training/se-m4a-relationship-drugabuse.pdf>




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Contemplation stage

- Now the user begins to think about doing something about his or her drug use, but has not yet reduced his or her level of use.
- You help the user at this stage by discussing the advantages and disadvantages of using, and the advantages and disadvantages of quitting.
- Make observations and provide information, but avoid arguing.

<http://www.unescap.org/esid/hds/training/se-m4a-relationship-drugabuse.pdf>



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Preparing for change

When the person accepts that he/she needs to make changes in drug use, it is time to undertake a full assessment to prepare for the change. It is important to know such things as:

- What drugs are being used?
- How much are used?
- How frequently are which drugs used (e.g., daily, 3 time per day, or weekly)?
- What methods of administration are used (e.g., inject, inhale, swallow) and if, how and why the methods may have changed?
- How is the user paying for the drugs?
- Whether the person is an experimental, functional, dysfunctional, harmful or dependent user?
- How he/she may have tried to give up or cut down in the past?
- What functions does the drug use serve?
- What supports the person has?
- Whether the drugs are used when the user is alone, with others, or both in both situations?

<http://www.unescap.org/esid/hds/training/se-m4a-relationship-drugabuse.pdf>




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Action stage

- At this point, the user attempts to quit, or at least reduce, his or her intake of substances. You can be more active at this stage by helping the person learn skills and develop strategies that are needed to live substance-free.
- The user will need to figure out, by looking at his or her own life, what people, places, feelings or things make him or her more likely to use drugs. Skills training, therapy, and, above all, supports, are necessary during this stage
- Just one day sober is an occasion to celebrate. Need to build on the client's strengths in order to reinforce that you believe in their ability to change.
- Once the user has identified some personal prompts for using, he/she can begin trying to eliminate them from his/her life. For some users, this may mean throwing away inhalant equipment, such as plastic bags and smoking instruments. For others, it may mean finding a job to avoid boredom. Yet other users may have to avoid friends who use drugs.
- There may be a need to talk about the past or work with the family, if there is one, and other people who are significant in the life of the child or youth. It may also mean changing work.

<http://www.unescap.org/esid/hds/training/se-m4a-relationship-drugabuse.pdf>



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Lapse stage

- After trying to abstain, most drug users will go through a stage in which they resume taking drugs at the same level as before, or, at a slightly reduced level. This may even happen multiple times.
- This is not failure, but simply a part of the process of changing. You need to prepare the user in advance for this stage and then help him/her get through it. It is best to help them figure out what made him/her use drugs again.
- Not a matter of if but when will relapse occur.
- Not all change strategies work for all users. When the user is ready to try to quit again, you can help the individual make a more effective plan of action.
- Relapse plan- cognitive in nature, discuss patterns & triggers, individualized plan.
- Average of 3 lapses per person before abstinence is maintained.

return to
Handout

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Most people relapse several times before achieving long-term abstinence.

www.nida.nih.gov/Diagnosis-Treatment/diagnosis6.html

Statistically 75-90% of all alcoholics or addicts will relapse within the first year of release from a traditional treatment program. www.drugandalcoholrehab.net/Relapse.html

HANDOUT –

Affirmations


Warning Signs of Relapse

Return to Alcohol Addiction & Recovery Chart

Maintenance stage

- The person in this stage is usually abstinent and wants to remain that way. You help the individual develop a healthy lifestyle, which might include moving to a neighborhood where drugs are less prevalent, finding activities that keep him/her off the streets and away from users and dealers, and spending free time with only non-users.
- Most importantly, individuals in this stage must learn to monitor themselves and recognize when they are entering risky situations.
- It is very difficult to maintain the change.
- The drugs had been helpful to them in so many ways, despite bringing them problems. They may grieve over the loss of the drugs, like the death of a good friend.
- It is important to keep in mind why they had used drugs in the past and what he/she is missing (e.g., pleasant hallucinations or feeling good) or what he/she now has to cope with without the drugs (e.g., painful memories of abuse, anxiety or depression).

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Adult Drug Court

- 85% retention rate (reach graduation)
- Takes an average of 24 months to complete the program.
- 1% recidivism rate
- Statistics on Family Drug Court not yet available since the program is too new.

Noble, 2005



Personal interview with Keith Noble. (9)

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